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Ophthalmic Literature

VOL. V. APRIL, 1915. NO. 4.

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LOCAL OPHTHALMOLOGICAL SOCIETIES.

The oldest ophthalmological societies undertook to draw their membership from broad territory, as the American Ophthalmological Society, the Ophthalmological Society of the United Kingdom, the Société Francaise d'Ophtalmologie and the Ophthalmologische Gesellschaft of Heidelberg. This necessitated the holding of meetings at long intervals, except in the case of the British Society with its membership concentrated in a small area. Even such societies, however, usually draw the bulk of their membership from a limited territory, as the American, which has always had two-thirds of its members living within two hundred miles of New York, where it came into existence. But the inclusive title and the long interval between meetings seemed to give the courage required for the launching of such an enterprise.

But the New York ophthalmologists having proved that a society devoted to ophthalmology was possible, quickly turned to the formation of a local society, which was organized within two months after the meeting of organization of the American Ophthalmological Society. This is, so far as we know, the oldest local society of the kind in the world.

Because it is the oldest it has been especially difficult to collect data with reference to its early history, and in the hope that our account of it can be rendered more complete its publication is deferred. The second local society to be formed was the Ophthalmological Society of Philadelphia, organized in 1870. It, however, continued its activities only a little more than five years. All the evidence seems to show that the time was then scarcely ripe for such special organizations in any locality.

But in 1884, in Boston, the New England Ophthalmological Society came into existence. We are particularly fortunate in having from its original secretary the account of its early history, enriched as it is with his mature judgment upon the value of such an organization. Its experience may well help those whose interest in ophthalmology is deep enough and earnest enough to induce them to make the necessary sacrifice of time and effort to secure this most valuable method of cultivating and improving their knowledge of their special work.

The essentials for such a society that are most commonly lacking are: appreciation of its value and courage to undertake it. It is to diffuse these that a series of sketches of local societies was undertaken. So persistently must courage be taught that it is justifiable here to quote at length from remarks made at the celebration of the

tenth anniversary of such a society (Ophthalmic Record, 18, p. 243).

"Every city of 100,000 inhabitants in America should have an active, flourishing, useful, highly prized ophthalmological society; cities of one-half that size might have them, if only the real possibilities of the situation could be appreciated. The real obstacle to their inception and development, back of all local jealousy and lack of self-confidence is a mistaken idea about the process of intellectual expansion and professional growth. The conception of intellectual development that holds that the necessary condition for it is a teacher of higher achievements, to stand over one and hammer things into him, is a conception that does scant credit to the child in the lower grades of a grammar school.

"Pretty much all that the greatest leaders of thought learn they learn through contact with their inferiors. For intellect is a product of contact—contact of some kind, the printed page, the spoken word, the intonation, the expression of face, the inherited results of an infinite number of contacts on the part of ancestors; and (if you will divide men into great and small) who have the greatest to mingle with except inferiors? But this grading men into big and little, better or worse, is in itself one of the commonest and most unprofitable of errors. The important thing is that we are all different. Looking at our cases with different eyes, these never look quite the same to any two of us. It is this getting out of ourselves, seeing things with other eyes for an instant, somewhat differently from our wont, that is the essential of intellectual growth. It is not that we shall see them with the eyes of some particular intellectual giant.

"The great teachers of ophthalmology have become great through contact, first with fellow students and teachers, and still more from contact with those who come to learn of them. These are the conditions of progress, of professional growth, which make valuable the position of a teacher, with students to spur him to intellectual activity; of hospital practice, where colleagues will give the needed stimulus. Such advantages have too often been confined to the holders of such positions. We are coming to understand that they might be opened to every practitioner of ophthalmology, who can occasionally meet with one or more of his colleagues to talk about the subjects in which they are naturally interested.

"We are in position to understand how much it improves one's grasp of a difficult case to talk it over with a friend. How much of a stimulus it is, reaching down into memory and arousing attention to its highest activity, to be appealed to by a colleague in regard to a case that is puzzling him; especially when we know that often he is quicker in understanding a case than ourselves. Or, when he states a case, and we find that his reading with regard to it has already extended to some book or paper with which we are not familiar. We can appreciate the satisfaction of watching from year to year how this fellow-member or that learns to avoid the error that he once fell into, or grows clearer as to matters about which he was

once hazy. We can appreciate the actual pleasure that it is to lay aside the air of dogmatic authority of the consulting room or the pedagogic attitude of the specialist addressing general practitioners, and come together on the frank basis of learning all we can from any one who will teach, either by what he knows or the mistakes he has made."

Let it be remembered that the success of the larger societies depends chiefly on the energy and devotion of one or a few men. In cities even smaller than fifty thousand, if the right men be there, the success of the local society is possible.

NEW ENGLAND OPHTHALMOLOGICAL SOCIETY.

On the 1st of May, 1884, the following circular was sent to the ophthalmologists of New England:

Boston, May 1, 1884.

It is proposed to organize in Boston a New England Ophthalmological Society, similar to the one for twenty years in successful operation in New York City.

Meetings to be held at the houses of members on the first Tuesday of each month, from November to April, inclusive, at 8 p. m. Adjournment to take place at 10 p. m., to be followed by a simple collation.

You are cordially invited to become a member, and are requested to address an answer to the undersigned.

(Signed) HASKET DERBY,
B. JOY JEFFRIES,
OLIVER F. WADSWORTH.

In response to the foregoing invitation on the 2nd of December, 1884, the following named gentlemen met at the residence of Dr. Jeffries:

Dr. H. W. Bradford of Boston, Dr. F. P. Capron of Providence, Dr. David Coggin of Salem, Dr. Hasket Derby of Boston, Dr. Gustavus Hay of Boston, Dr E. E. Holt of Portland, Dr. David Hunt of Boston, Dr. B. Joy Jeffries of Boston, Dr. H. G. Miller of Providence, Dr. Francis P. Sprague of Boston, Dr. Myles Standish of Boston, Dr. Samuel B. St. John of Hartford, Dr. Oliver F. Wadsworth of Boston, Dr. J. J. B. Vermyne of New Bedford.

The following gentlemen were not present, but had signified their intention to join in forming the society:

Dr. Lewis S. Dixon of Boston, Dr. Ezra Dyer of Newport, Dr. J. A. Spaulding of Portland, Dr. Charles H. Williams of Boston.

The meeting organized with Dr. Hay as temporary chairman and Dr. Standish as temporary secretary.

Dr. Derby presented a form of constitution and by-laws which, with slight modifications, was adopted. This constitution specified that membership was not necessarily limited to ophthalmologists, but any medical man interested in ophthalmology should be eligible.

At this meeting Dr. Jeffries exhibited the first ophthalmoscope

ever imported into this country, which formerly belonged to the late Dr. Dix.

The society organized by the election of the following officers:

President—Dr. Hasket Derby.

Vice President—Dr. J. J. B. Vermyne.

Secretary—Dr. Myles Standish.

An admission committee was established which should consider the names of gentlemen proposed for membership and report their recommendation to the society. Election was by the society. Negative votes to the number of one-fourth of those cast excluded the candidate from the society.

The society early adopted and has since maintained the ethical standards of the American Ophthalmological Society.

For nine years the society met at the homes of members living in Boston and was from time to time entertained by out-of-town members at various Boston hotels.

At the meeting on November 7, 1893, Dr. Standish extended to the society on behalf of the managers of the Massachusetts Charitable Eye and Ear Infirmary, an invitation to meet in the future at that institution and granting to the society the use of the trustees' parlor and the officers' dining room.

This invitation was accepted and all meetings of the society have been held at the Infirmary since that date.

When the society was organized it was determined that there should be no formal papers and that reports of the proceedings of the society should not appear in print.

It was the custom of the president to begin at one side of the room and ask each gentleman in succession for an oral communication. If the one called upon had any case which had interested him since the previous meeting he made a brief oral report. The case was then discussed by any one present who chose to offer his views of the case in hand or the subject under discussion.

The freedom and sincerity of the discussions under these rules were noteworthy. It is also worthy of note that every one, from the oldest to the youngest member, felt free to report his cases.

In course of time the society attendance became so large that this method was impractical and less instructive, owing to an increasing disinclination of the men to take part in the discussions, and on December 5, 1899, it was voted to ask for formal papers, and the first paper was presented at the following meeting on "A Case of Concentric Diminution of Both Visual Fields, Probably of Cortical Origin," by Dr. O. W. Wadsworth.

Since this date the meetings have consisted of the formal papers and the exhibition of patients either from the wards of the Infirmary or private patients.

Originally there was no limitation in membership, but at the meeting on February 4, 1896, the membership was limited to fifty. The

number has since been increased and the limitation now stands at sixty members.

The society has never omitted a regular meeting since its organization and the meeting on November 10, 1914, was the one hundred and eighty-first meeting.

From the beginning the society has always adjourned by limitation at a specified hour, 10 p. m., and has had a collation and social hour after adjournment which is by no means the least of the benefits that the society confers on its members.

The society has opposed and advocated measures concerning which it had special knowledge, before the Great and General Court of the Commonwealth of Massachusetts as the Legislature calls itself; has entertained visiting scientific societies, and in general filled a useful position in the community.

It still insists that its transactions shall not be reported to the medical journals.

The present secretary is Dr. W. Holbrook Lowell of Boston.

MYLES STANDISH.

THE FORMATION OF A LOCAL SOCIETY.

The first essential for a local society is prospective members. Of these there should be at least two. A larger number may be desirable. The Colorado Ophthalmological Society organized with three present, and two others promised. As it has developed into a society of thirty-five members, in a region where population is sparse and cities long distances apart; as it has never failed to hold a regular meeting, and shows an average attendance of almost two-thirds of its membership, and as it has enormously increased the scientific activity of these members, besides contributing materially to the world's ophthalmic literature; we can safely assume that this number of prospective members abundantly justifies the formation of such a society.

About the only essential qualification for membership is an interest in ophthalmology, and in the majority of instances this interest may be latent. Where a society has not existed it must be chiefly latent. Still an active interest is required to kindle that which is latent. The active interest may be contributed by some young man who has just come from studying ophthalmology in one of the great centers, or by an older practitioner returning from a period of post-graduate work, or even from contact with other ophthalmologists at the annual meeting of one of the national societies.

There must also be some appreciation, both of the value of such an organization and of the fact that it does not require a group of particularly talented and exceptionally agreeable members of the profession to make such an organization successful. There is no man who has succeeded in establishing himself in ophthalmic practice anywhere, no young man who will succeed, but who meets with cases that he would like to discuss with a colleague, and that by a little reading and study he could make interesting to a colleague. Anyone

who understands this and has the interest in ophthalmology that justifies him in undertaking ophthalmic practice, is first-class material for such a society.

Given the possible members of such a society, the first step is to bring them together, and this is often the most difficult step in the whole process of organization. Where all live in one city it is generally well to previously talk over the project with the different individuals; then the visit of someone from a distance whom all desire to meet, may be made the occasion for bringing together those who have regarded each other with suspicion or even dislike, giving opportunity for each to find out that the other is not so bad a fellow as he was painted by imagination, and the stories of patients who prefer changing doctors to paying their bills.

At such a meeting, and with the aid of the guest of the occasion, it will almost always be possible to get enough promises to attend another gathering to make the start. If at the second gathering one or two interesting cases can be shown and discussed, some appreciation of the possibilities of such an organization will begin to dawn on all who attend it.

In the matter of program the chief dependence, and it may well be the whole dependence, is to be placed upon the exhibition and reporting of cases. This has been the method of every successful local ophthalmological society. Some have excluded formal papers or set discussions. This is not necessary, but they should not be depended upon for the chief interest of the meeting.

With regard to getting patients to show themselves at these meetings: It is quite unnecessary to have at command a public clinic. More than one-half our private patients are pleased rather than offended at being made the subject of special interest and attention, and almost always an extraordinary or puzzling case can be induced to submit to an examination that will have more or less of the value of a consultation. So long as the society is small it is really easy by the exercise of a moderate amount of tact, such as every successful professional man must possess, to get together all the cases that can profitably be examined and discussed in an evening.

The great advantage of cases in this connection, especially of those that can be exhibited, is that every one of them introduces an element of novelty. It is impossible for such meetings to become uninteresting because the discussion gets into old ruts. The New England Society came finally to hearing and encouraging formal papers, but only when its membership had outgrown the number most favorable for the examination and discussion of cases.

Much may be said for the "collation" in connection with such meetings. Some societies have a dinner before the scientific session; others have an annual dinner. But in some very successful organizations nothing of the kind is attempted. This is a detail to be decided by local feeling. But it is coming to be generally understood in the medical profession that there is no necessary conflict between science and good-fellowship.

The plan of adjourning at a fixed hour, as they do in Boston, has

very distinct advantages. Sam Weller's observation: "She'll vish there wos more, and that's the great art of letter-writin'," is founded on a very general trait of human nature. Scientific discussions are generally decidedly improved by a time limit. Only when he is compelled to confine his remarks to the most important point will the average speaker do so. To get over-tired of a meeting is unfavorable to the success of the next. What is lost by cutting the proceedings short at one time will be more than repaid by subsequent gains.

To some extent the discussions in the smaller body should train for speaking in the larger scientific meetings, and the cultivation of directness and brevity of statement is greatly needed among the members of all scientific societies.

BOOK NOTICES.

Transactions of the College of Physicians of Philadelphia. Third Series, Volume 36. 8vo. 502 pp. Illustrated. Edited by Walter G. Elmer. Published by the College. Philadelphia, 1914.

This publication is of interest to the ophthalmologist because it includes the proceedings of the Section on Ophthalmology of the College for the year 1914. These occupy fifty-three pages, the different communications and the discussions being given in abstract.

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Abstracts From Foreign Journals

Albanese, N. Anatomic Researches as to the Topography of Elliot's Trephining in Relation With the Angle of the Anterior Chamber. (Archivio di Ottalmologia, 22nd year, p. 49.)

Experiments were undertaken on cadavers to determine the distance between the anterior margin of the separated conjunctiva and the anterior attachment of the ciliary muscle. It was found that in all directions (above, below and on both sides) the dissection of the conjunctival flap, done with rigorous technique and the proper instruments, can be carried almost to the limbus: that the trephining, if well executed, is distant 1 10 mm. from the limbus: and that, for the trephine hole to be in full correspondence with the anterior chamber it is necessary above to use a trephine of a maximum diameter of 1.5 mm; below of 1 mm., and at the sides of not more than 0.5 mm.

Axenfeld, T. Küpferle, L., and Wiedersheim, O. Glioma of the Retina and Intraocular Radiotherapy. (Klinische Monatsblätter für Augenheilkunde, vol. 54, p. 61.)

This is a group of statements by the respective authors, based upon a case of which a preliminary report was published last year (K. M. f. A., v. 52, p. 426). The right eye of a child of 8 months was enucleated on 18th January, 1914, on account of glioma. This eye was already somewhat enlarged, the vitreous being almost filled by a typical growth with numerous Wintersteiner rosettes. The optic nerve was healthy at the point of section. In accordance with Axenfeld's custom, the second eye was examined ophthalmoscopically during the narcosis used for enucleation. At this time a prominent tumor was seen peripherally on the nasal side of the fundus. A more complete ophthalmoscopic examination was later made under narcosis. Three tumors were found—the large one to the nasal side and not delimitable anteriorly, one below the macula of about eight disc diameters, and a still smaller one two disc diameters above the disc. Clinically fixation was uncertain. The X-radiations were carried on for a period of about ten months, being used both on the orbit of the enucleated eye and on the retained eye. During this period frequent ophthalmoscopic examinations were made under narcosis. There was gradual atrophy of all three growths. At the last examination under narcosis the site of the smallest tumor was represented by a delicate, scarcely visible discoloration of the retina; the growth below the macula was apparently entirely healed, and the largest mass had shrunken to such an extent that there was scarcely any perceptible prominence above the retinal level. The fixation of the eye was central and steady, and vision apparently good. The action of the radiotherapy had therefore been elective, destroying the tumor without causing discoverable change in the other tissues.

Experiments on rabbits were performed by Wiedersheim, who reports that large doses of properly filtered rays caused no demonstrable injury to the ocular interior of these animals, and particularly to the retina.

Küpferle deals with the theoretic and technical questions of intraocular radiotherapy. Some years ago Birch-Hirschfeld showed that

unfiltered X-rays, in certain doses and at a focal distance from the skin of 10 cm., could produce severe changes in certain parts of the eye, especially the retina. But his observations were limited to unfiltered and rays of medium softness, such as are now only used for superficial disease of the skin. The unsatisfactory results hitherto obtained with radiant treatment of intraocular tumors were probably also due to imperfect methods. It is now known that very small doses of the X-rays stimulate growth, whereas larger doses have an inhibitory effect. The result is materially affected not only by the quantity but by the quality of the rays. It has been found that the gamma rays of radioactive substances and the hard Röntgen rays are the ones which destroy and inhibit the growth of tumor tissue. The harder the radiation is the less of it is absorbed in the superficial epithelial layers. Aluminum has proved to be the best filter material: it not only cuts out the soft rays, but by its own complex secondary radiation increases the hardness of the rays which pass through. The most suitable thicknesses of it are 3, 4 and 5 mm. It is also necessary to modify the electric current in such a way as to produce the greatest possible hardness of radiation from the tube itself. In Axenfeld's patient the treatments, given at intervals of from two to fourteen days, were of from 8 to 32 minutes' duration; and the surface energy according to Kienböck's enumeration varied from 10 X to 35 X. The thickness of the aluminum filter was from 3 to 5 mm., and the focal distance from the skin almost always 22 cm.

Axenfeld urges that in every case of unilateral glioma of the retina the second eye should, without fail, be examined to its utmost periphery, under narcosis, if not otherwise practicable. If this is done, he is satisfied that the disease will show itself to be much more frequently bilateral than has previously been supposed. Further, every case of enucleation for glioma, even in the earliest stage, should be submitted to irradiation. Amaurotic eyes should be enucleated, but if enucleation is refused, or if relapses occur, radiotherapy should be attempted. For beginning glioma on other hand, for glioma in the still seeing eye (naturally only seen by the physician in the second eye), the use of radiotherapy is not only justified but indicated.

Fava, A. The Microbic Flora of the Conjunctiva Before and After Dacryorhinostomy. (La Clinica Oculistica, 14th year, pp. 1793 and 1889.)

Fava's researches lead him to the following conclusions: The most frequent and important organism in the conjunctiva during pathological processes in the lacrimal passages is the diplococcus of Fraenkel. Next in order of frequency are the xerosis bacillus, which never has a pathogenic action, and the staphylococcus. Rarely anaerobic germs or other microbes are found.

Dacryorhinostomy decidedly reduces the number of microorganisms existing in the conjunctival sac during dacryocystitis, the average number of colonies found before operation having been 1,099, as compared with an average of 316 colonies from eight to ninety days after dacryorhinostomy. Whereas after the other operations practiced on the lacrimal passages pathogenic germs, among them the diplococcus of Fraenkel, were still encountered; after dacryorhinostomy virulent germs, including the diplococcus of Fraenkel, were never found.

The most propitious time for operations on the globe is from the thirtieth day after dacryorhinostomy, when the conjunctival flora tends to resemble that of the normal conjunctiva. After dacryorhinostomy the use of the sterile compress is followed by an increase in number and virulence of the bacteria in the conjunctiva; so that it is desirable to use during the first days after operation merely a simple protective screen.

Laganá, G. Passage of Antibodies Into the Ocular Fluids in Normal and Pathologic Conditions of the Eye. (La Clinica Oculistica, 14th year, pp. 1845 and 1913.)

The results of an extensive series of experiments upon rabbits are described. The antibodies passed from the blood into the aqueous and vitreous of non-irritated eyes merely in very minute quantities. All the causes affecting the eye, whether physical, chemical or bacterial, determine an increase in the passage of immune antibodies, in proportion to the amount of irritation produced. All the experiments gave evidence that the vitreous participates to a less degree than the aqueous in the processes of immunity. The low percentage of antibodies present in the normal ocular fluids, in comparison with the blood, depends on the lower proteid content of the former. Thus every cause which increases the amount of blood albumens in the aqueous and vitreous also causes an increase in their antibody content. The fact that fewer antibodies enter the vitreous than the aqueous has so far not been adequately explained.

Pálich-Szántó, O. The Genesis of Traumatic Disease of the Macula. (Klinische Monatsblätter für Augenheilkunde, vol. 54, p. 56.)

A soldier was shot in the right superciliary arch. Although the shot did not directly involve the eye, the visual acuity was suddenly diminished, and the eye at once became painful and red. At examination six days later there was moderate lacrimation, and there was marked conjunctival and ciliary injection of the eyeball. At the lower border of the macula lutea was a crescentic thin strand of gray-greenish color, with three branches radiating downward. There were fine punctate hemorrhages in the fundus, especially below. Ten days later strands like those already described ran in every direction from the macula. They protruded a little from the level of the retina and had a decided green color. There was no pigmentation. At and after the next examination five days later the strands became less distinctly outlined, and their color changed to yellowish. The final condition was a somewhat indistinctly outlined yellow area at the macula, about the size of the disc, and not surrounded by pigmentation. The visual acuity was 5/30 at the first examination, and so continued. The authoress diagnoses the condition as a localized plicated detachment of the retina, due to hemorrhage either between the retina and choroid or in the deeper layers of the retina. She concludes that by the development of connective tissue in such cases the picture of retinal detachment may give place to that of retinitis proliferans.

Scalinci, N. Heterochromia and Paralysis of the Sympathetic (Archivio di Ottalmologia, 22nd year, p. 57.)

The clinical basis of this article is a single case of congenital heterochromia iridis, with cataract in the blue right eye. The patient was 15 years old. The right palpebral aperture was slightly narrower than the left, but both enlarged equally under cocaine, while under the same drug the right pupil dilated rather less than the left. There was no history of inflammation and no precipitates could be discovered on the posterior surface of the cornea or on the lens capsule, nor did any such deposits appear after operation for extraction of the cataract, or after a secondary operation for division of a capsular membrane. The corrected vision of the cataractous eye after operation was 1/2. Both in the patient and in his mother, in addition to inequality of the palpebral apertures, there was an under-development of the right side of the face. The literature of the subject is reviewed at some length. The author suggests that a better name for heterochromia would be anisoiridochromia. Congenital or acquired primary heterochromia he regards as in all probability depending upon a lesion

of the cervical sympathetic. He does not believe in the correctness of the common supposition that the lighter eye has been the seat of a slow inflammation of the ciliary body. He believes that the theory of a disturbance, usually paralytic, of the cervical sympathetic is adequate to explain not only the defective pigmentation, but also the presence of deposits on the posterior surface of the cornea and the supposed results of chronic uveitis found histologically in the uveal tract. The cataract is also attributed, somewhat indefinitely, to vasomotor paralysis.

Tosi, G. Muscular Shortening According to Lagleyze in the Treatment of Strabismus. (Archivio di Ottalmologia, 21st year, p. 617.)

Writing from Angelucci's clinic at Naples, the author describes and illustrates the results obtained in six cases of convergent strabismus. He regards Lagleyze's operation as the best of the capsulomuscular advancements. He considers the operation, however, inferior to Landolt's muscular advancement in high grades of alternating strabismus.

Re, F. Some Ocular Measurements and a New Excursiometer and Pupillometer. (Archivio di Ottalmologia, 22nd year, p. 113.)

Sixteen printed pages are devoted to the explanation and description of this device, which consists essentially of a piece of glass representing a part of a hollow sphere whose radius of curvature is 28 mm., or twice the commonly accepted distance between the cornea and the center of rotation of the eye. The vertical meridian of the glass excursiometer is shorter than the horizontal, to correspond with the shape of the orbit. The instrument is marked with circles, the innermost of which has a diameter of 4 mm., and the remainder of which are concentric with the first and are placed at 2 mm. intervals from it and from each other. Reckoned from the center of rotation of the eye, and with the instrument at 14 mm. from the cornea and concentric with the curve of rotation, each 2 mm. interval on the instrument represents 1 mm. of rotation, or 4° 5′ 40″. The author measures with the instrument the difference between the position of the squinting eye in fixation or deviation. He appears to lay insufficient emphasis upon two difficulties in the use of the instrument, viz., that of being certain that it is placed exactly at 14 mm. from the cornea, and that involved in the fact that for results to be accurate the observer's eye must be in a straight line with the visual axis of the eye which is being examined.

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